

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9405

CERTIFICATE OF DEATH

0941100  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Accokeek 16 X 0.2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Physicians Memorial Hospital</b>		d. STREET ADDRESS <b>Rt. 1, Box 437</b>	
3. NAME OF DECEASED (Type or print) First <b>Russell</b> Middle <b>A</b> Last <b>Allen</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>19,</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 13, 1885</b>
9. AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Special Police</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Parker Allen</b>		14. MOTHER'S MAIDEN NAME <b>Sallie Hardwick</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>0</b>		16. SOCIAL SECURITY NO. <b>1</b>	
17. INFORMANT <b>Evelyn A. Henkel, Accokeek, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized metastasis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of urinary bladder</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b> <b>7 yrs.</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>14 Sept. 1957</b> to <b>19 Sept. 1957</b> , that I last saw the deceased alive on <b>18 Sept. 1957</b> , and that death occurred at <b>7:45 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>V. B. DETTOR</b>		ADDRESS (Street, city or town, state) <b>La Plata, Md.</b>	
PHYSICIAN'S NAME (Type) <b>V. B. DETTOR</b>		DATE SIGNED <b>19 Sept. 1957</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-21-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Glenwood</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers, 517 - 11th St. S. E., D. C.</b>		24a. REC'D BY REGISTRAR <b>DATE 9/19/57</b>	
24b. REGISTRAR'S SIGNATURE <b>Julia H. Pacey</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed in the hospital or attending physician's file. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

SEP 24 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM3. Page 3 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										09411	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 100	
1. PLACE OF DEATH a. COUNTY <i>Charles</i>					2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Charles</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lafayette</i>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>XO Lafayette, Md</i>			d. STREET ADDRESS <i>1</i>			
6. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Longview Hosp</i>										e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>JAMES LARRY BEAN</i>					4. DATE OF DEATH <i>9</i> Month <i>13</i> Day <i>19</i> Year <i>57</i>						
5. SEX <i>M</i>		6. COLOR OR RACE <i>C</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>12-24-56</i>		9. AGE (In years last birthday) <i>8</i> yrs. <i>10</i> mos. <i>14</i> days		IF UNDER 1 YEAR Hours <i>16</i> Min. <i>14</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Francis Edward Bean</i>					14. MOTHER'S MAIDEN NAME <i>Mary Catherine Bean</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Diarrhoea</i> <i>571.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Inf</i> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <i>9-12-57</i> <i>12-13-57</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Malnutrition</i>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>E. J. ELEN</i>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED <i>9-12-57</i>			
EXAMINER'S NAME (Type) <i>E. J. ELEN</i>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9-15-57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Newtown</i>			22d. LOCATION (City, town, or county) (State) <i>Lafayette Md</i>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Richard Lee LaPlata</i>					ADDRESS <i>Lafayette</i>		24a. REC'D BY REGISTRAR DATE <i>9/19/57</i>		24b. REGISTRAR'S SIGNATURE <i>Julia H. Rosey</i>		

2066287XV5

STATE DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
SEP 20 1957  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

094126

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Potomac Heights</i>		c. LENGTH OF STAY IN 1b <i>6 yrs</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Charles O. Billingsley</i>		4. DATE OF DEATH <i>Sept. 19 19 57</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-23-00</i>
9. AGE (In years last birthday) <i>56 yrs.</i>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Road Inspector</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>County Roads</i>	
11. BIRTHPLACE (State or foreign country) <i>Colonial Beach, Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>James O. Billingsley</i>		14. MOTHER'S MAIDEN NAME <i>Susie Baker</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>577-16-4489</i>	
17. INFORMANT <i>Mrs. Chas. O. Billingsley</i>		Address <i>Potomac Heights Rd</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Coronary Occlusion</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>704.9</i> DUE TO <i>Fracture right foot (2 wks old - reduced &amp; cast applied)</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>704.9</i>			INTERVAL BETWEEN ONSET AND DEATH <i>3 1/2 hours</i>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Frank A. Susan</i>		DATE SIGNED <i>9-19-57</i>	
EXAMINER'S NAME (Type) <i>Frank A. Susan</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>9-21-1957</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Oak Grove</i>	22d. LOCATION (City, town, or county) (State) <i>Oak Grove, Virginia</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Gale &amp; Whittingly Wash D.C.</i>		24. REG. BY REG. NO. <i>REP-021857</i>	
ADDRESS <i>131-11</i>		24b. REGISTRAR'S SIGNATURE <i>Edley Price</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



NEW YORK STATE DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

SEP 20 1957

RECEIVED

9408

## CERTIFICATE OF DEATH

Reg. Dist. No.

105

1. PLACE OF DEATH <sup>1</sup> a. COUNTY <b>WYALDORF</b> <b>CHARLES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CHARLES</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rt 1, Box 210</b>				c. LENGTH OF STAY IN 1b <b>15 months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>Rt 1, Box 210 WALDORF X 2</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>OSCAR</b> First <b>JAMES</b> Middle <b>Bostwick</b> Last				4. DATE OF DEATH Month <b>Sept.</b> Day <b>11</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 31 1898</b>	9. AGE (In years last birthday) <b>58</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist NAVAL Gun Factory</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>PA.</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES D. Bostwick</b>				14. MOTHER'S MAIDEN NAME <b>ADELIA COYKENDALL</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, state branch, grade or dates of service) <b>WORLD WAR I</b>				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>CLARENCE R Bostwick</b>				Address <b>5816 4th Ave NW Wash DC</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>coronary insufficiency</b> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>1957</b> to <b>1957</b> , that I last saw the deceased alive on <b>9/15</b> , 19 <b>57</b> , and that death occurred at <b>9:30 AM</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>A. Schwartzman</b> M.D.				DATE SIGNED <b>2027</b> <b>Nicholas</b>			
PHYSICIAN'S NAME (Type) <b>A. Schwartzman</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>9-16-57</b>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NAT CEM</b>		22d. LOCATION (City, town, or county) (State) <b>ARLINGTON, VA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee FUNERAL Home</b>				24a. REC'D BY REGISTRAR <b>300-4 S. N.E.</b>		24b. REGISTRAR'S SIGNATURE <b>M. L. Monroe</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS  
COUNTY OF WORCESTER  
CITY OF WORCESTER

DECEASED  
NAME  
AGE  
SEX  
DATE OF BIRTH  
PLACE OF BIRTH  
DATE OF DEATH  
PLACE OF DEATH  
CAUSE OF DEATH  
MANNER OF DEATH  
SIGNATURE OF REGISTRAR  
OFFICIAL SEAL

BUREAU V. S.

SEP 13 1957

RECEIVED



## CERTIFICATE OF DEATH

0941500  
Reg. Dist. No.

9409

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>				c. LENGTH OF STAY IN 1b <b>Welcome Md.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Physicians Memorial Hospital</b>				d. STREET ADDRESS <b>1</b>			
3. NAME OF DECEASED (Type or print) First <b>Joyce Marie</b> Middle <b>Cooper</b> Last <b>Cooper</b>				4. DATE OF DEATH Month <b>Sept</b> Day <b>9</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>col</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept 9. 1957</b>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>George Vincent Riley</b>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <b>Mary Lucille Cooper</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>mother</b>		Address <b>Welcome, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory collapse</b> 7615 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Premature separation of placenta</b> DUE TO (c) <b>Premature labor</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b> <b>5 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>A. O. Woodydy</b> M.D. <b>La Plata, Md.</b>				PHYSICIAN'S NAME (Type) <b>A. O. Woodydy, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept 11-1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Green Point meck</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Archart Inc La Plata, Md</b>				24a. REC'D BY REGISTRAR DATE <b>9/16/57</b>		24b. REGISTRAR'S SIGNATURE <b>Julia H. Pacey</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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# CERTIFICATE OF DEATH

MAINTAIN STATE DEPARTMENT OF HEALTH—BATTING ONE IN

BUREAU V. 8

SEP 18 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09414

9410

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Tronsides</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Tronsides</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>COLBERT DENT</i>		d. STREET ADDRESS <i>1</i>	
3. NAME OF DECEASED (Type or print) <i>Dent</i> Last First Middle <i>COLBERT</i>		4. DATE OF DEATH Month <i>9</i> Day <i>29</i> Year <i>1957</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-1-04</i>
9. AGE (In years last birthday) <i>52</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <i>md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Thomas Dent</i>		14. MOTHER'S MAIDEN NAME <i>Anna F.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Colbert E Dent Tronsides</i> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>HEMORRHAGE</i> DUE TO <i>GUNSHOT WOUND R+SUBCLAVIAN</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>ARTERY SEVERED</i> DUE TO (c) <i>ARTERY SEVERED</i>		INTERVAL BETWEEN ONSET AND DEATH <i>9-29-57</i> <i>9-29-57</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>SHOT BY SON'S SHOTGUN</i>	
20c. TIME OF INJURY Month, Day, Year <i>1</i> Hour <i>9-29</i> 19 <i>57</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>HOME</i>		20f. CITY OR TOWN (County) (State) <i>TRONSIDES CHAS MD.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. J. Edelen</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. J. EDELEN MD.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Oct 4-1957</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>mt Hope</i>		22d. LOCATION (City, town, or county) (State) <i>Tronsides md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert Mc Spatola md.</i> ADDRESS <i>Johnson - Denton Wash D.C.</i>		24a. REC'D BY REGISTRAR <i>10/1/57</i>	
		24b. REGISTRAR'S SIGNATURE <i>Julius H. Gray</i>	

U. S. A. GOVERNMENT

OCT 100

RECEIVED

9411

## CERTIFICATE OF DEATH

Reg. Dist. No.

100

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) c. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Physicians Memorial Hospital</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Perry U. Gilroy</u>				4. DATE OF DEATH Month Day Year <u>September 2 1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 22, 1876</u>		9. AGE (In years last birthday) <u>81</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Blacksmith</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George Gilroy</u>				14. MOTHER'S MAIDEN NAME <u>Emily Anderson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT Address <u>Pauline M. Gilroy Remondway</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of the prostate</u> <u>111X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March</u> 19 <u>57</u> , to <u>2 Sept</u> 19 <u>57</u> , that I last saw the deceased alive on <u>2 Sept</u> 19 <u>57</u> , and that death occurred at <u>11:15 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>La Plata, Maryland</u>				22. DATE SIGNED <u>Sept 57</u>			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>[Signature]</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>9-5-57</u>		<u>Bumpy Gotes</u>		<u>Remondway Md.</u>	
24a. REC'D BY REGISTRAR				24b. REGISTRAR'S SIGNATURE			
<u>9/7/57</u>				<u>Julia H. Barry</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



RECEIVED

SEP 10 1957

BUREAU V. S.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 100

9412

Item 2 filed 9-23-57 at

1. PLACE OF DEATH a. COUNTY <u>Charles</u> b. CITY OR TOWN (If not in corporate limits, write RURAL and give nearest town) <u>White Plains</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Plains</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>ELWOOD</u> Last <u>MARSHALL</u>		4. DATE OF DEATH Month <u>9</u> Day <u>11</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-25-1891</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>11</u>	11. IF UNDER 24 HRS. Hours <u>18</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during best of working life, even if retired) <u>Balmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Mr. Henry Marshall</u>		14. MOTHER'S MAIDEN NAME <u>Mary Louise Clark</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or institution) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Henry Aubrey Marshall</u>		Address <u>Bonful Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion (myocardial infarction)</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c) _____ DUE TO (a) _____ (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>9-11-57</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month, Day, Year _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>E. J. Edele</u> EXAMINER'S NAME (Type) <u>E. J. EDELEN</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>9-16/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph</u>		22d. LOCATION (City, town, or county) <u>Pumbret Md.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHNSON + JENNINS WASH. D.C.</u>		24a. REC'D BY REGISTRAR <u>9/16/57</u> 24b. REGISTRAR'S SIGNATURE <u>Julia H. Prater</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

1957

BUREAU V. 1

Item 18 Film 221 1-57-57

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 100

9413

1. PLACE OF DEATH a. COUNTY <b>Charles</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Marysino</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Charles</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Marysino</b>				d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>BRENDA</b> Middle <b>CAROL</b> Last <b>MAY</b>				4. DATE OF DEATH Month <b>September</b> Day <b>18</b> Year <b>19 57</b>				5. SEX <b>Female</b>				6. COLOR OR RACE <b>White</b>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>May 9, 1957</b>				9. AGE (In years last birthday) yrs. <b>4</b> Months <b>9</b> Days <b>9</b> Hours <b>Min.</b>				10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>			
10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>Md</b>				12. CITIZEN OF WHAT COUNTRY? <b>usa</b>				13. FATHER'S NAME <b>Stanley May</b>			
14. MOTHER'S MAIDEN NAME <b>Bettie Sidenstricker</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>				16. SOCIAL SECURITY NO.				17. INFORMANT <b>Stanley May Marysino</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory infection with incipient bronchopneumonia</b> DUE TO <b>491X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c)												INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .															
ACTUAL SIGNATURE <b>Russell S. Fisher</b>				M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>				DATE SIGNED <b>9/18/57</b>											
22a. BURIAL, CREMATORY, REMOVAL (Specify)				22b. DATE THEREOF <b>9-120-57</b>				22c. NAME OF CEMETERY OR CREMATORY <b>Dentsville</b>				22d. LOCATION (City, town, or county) (State) <b>Md</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Archibald Mc Leplato</b>				ADDRESS				24a. REC'D BY REGISTRAR <b>9/24/57</b>				24b. REGISTRAR'S SIGNATURE <b>Julius H. Pusey</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

SEP 22 1957

RECEIVED



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-1003. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for a burial-cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

094190

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE <u>NC</u> b. COUNTY <u>Buncombe</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pittsboro</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Asheville NC</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Clarence Lee Maynard</u> First Middle Last		4. DATE OF DEATH <u>Sept 15</u> 19 <u>57</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-18-1929</u> 28 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>US Government</u>	11. BIRTHPLACE (State or foreign country) <u>NC</u>
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>Nettie Maynard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>244-50-5397</u>	
17. INFORMANT <u>Nettie Maynard</u> Address <u>Asheville NC</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage</u> DUE TO (b) <u>Epigastric Gunshot wound</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>3 min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY <u>5:30</u> p.m. <u>SEPT. 15, 57</u> Month, Day, Year	20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> <u>Not while at work</u> <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>HOME</u>	20f. (City or town) <u>CHARLES</u> (County) <u>MD.</u> (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>V.B. DETTOR</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>V.B. DETTOR MD.</u>		DATE SIGNED <u>SEPT. 17, 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>9-17-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>	22d. LOCATION (City, town, or county) <u>Asheville NC</u> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard Lee de Plata</u> ADDRESS <u></u>		24a. REC'D BY REGISTRAR <u>Julia Mason</u> DATE <u>9/19/57</u>	24b. REGISTRAR'S SIGNATURE <u>Julia Mason</u>

RECEIVED  
SEP 27 1911  
BUREAU V. S.

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. After this time, a copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time, a copy has been executed by the attending physician and completely filled in by the funeral director, the copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9415

## CERTIFICATE OF DEATH

09420

Reg. Dist. No. 102

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Charles</i>		STATE <i>MD</i> COUNTY <i>Charles</i>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <i>Nanjemo</i>		LENGTH OF STAY (In this place)		CITY OR TOWN <i>Nanjemo</i>		STREET ADDRESS (If rural, give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Glades Marie Perry</i>				STREET ADDRESS			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <i>(Female Infant) Posey</i>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <i>Sept 20 1957</i>			
<b>5. SEX</b> <i>Female</i>	<b>6. COLOR OR RACE</b> <i>Negro</i>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <i>Single</i>	<b>8. DATE OF BIRTH</b> <i>9-20-57</i>	<b>9. AGE last birthday</b> yrs.		<b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Infant</i>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <i>Nanjemo, MD</i>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>U.S.</i>	
<b>13. FATHER'S NAME</b> <i>Archie Posey</i>				<b>14. MOTHER'S MAIDEN NAME</b> <i>Ordelia Edynor</i>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <i>No</i>		<b>16. SOCIAL SECURITY NO.</b> <i>—</i>		<b>17. INFORMANT &amp; ADDRESS</b> <i>Archie Posey, Nanjemo MD</i>			
<b>18. MEDICAL CERTIFICATION</b>				<b>19. MEDICAL CERTIFICATION</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>20. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <i>Prematurity</i>				ANTECEDENT CAUSE(S) DUE TO (B) <i>(6 mo Premature)</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				INTERVAL BETWEEN ONSET AND DEATH <i>9:30 am</i>			
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <i>9/20</i> , 19 <i>57</i> , to <i>9/20</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>9/20</i> , 19 <i>57</i> , and that death occurred at <i>9:30 am</i> , from the causes and on the date stated above.							
<b>SIGNATURE</b> <i>Frank G. Dusan M.D.</i>				<b>DATE SIGNED</b> <i>9/20/57</i>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <i>Burial</i>		<b>DATE THEREOF</b> <i>Sept 20 1957</i>		<b>NAME OF CEMETERY OR CREMATORY</b> <i>mt Hope</i>		<b>LOCATION (City, town, or county)</b> <i>Ironides MD</i>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <i>clv Thompson</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Archie Posey Nanjemo MD</i>		<b>ADDRESS</b>	
<b>DATE</b> <i>Sept 20 1957</i>							

BOHANN V. E.

1937

RECEIVED

9416

## CERTIFICATE OF DEATH

09421  
Reg. Dist. No. 102

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Nanjemo</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Nanjemo</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Robert</i> Middle <i>Possey</i> Last <i>Possey</i>		4. DATE OF DEATH Month <i>Sept</i> Day <i>20</i> Year <i>1957</i>	
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>NEGRO</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-28-57</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Infant</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State and foreign country) <i>Nanjemo, MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Archie Possey</i>		14. MOTHER'S MAIDEN NAME <i>Ornelie Raynor</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <i>NO</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Archie Possey</i> Address <i>Nanjemo, MD</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>776X</i> DUE TO <i>Primaturity (Em. Premature)</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>5 min</i> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>9/20</i> , 1957, to <i>9/20</i> , 1957, that I last saw the deceased alive on <i>9/20</i> , 1957, and that death occurred at <i>5:05 A.M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Indian Head MD</i> DATE SIGNED <i>9/20/57</i> ACTUAL SIGNATURE <i>Frank A. Susan</i> M.D. PHYSICIAN'S NAME (Type) <i>Frank A. Susan MD</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Sept 20/1957</i>	22c. NAME OF CEMETERY OR CREMATORY <i>mttfope</i>	22d. LOCATION (City, town, or county) (State) <i>md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Archie Possey Nanjemo, MD</i> ADDRESS		24a. REC'D BY REGISTRAR <i>Sept 20 57</i>	24b. REGISTRAR'S SIGNATURE <i>dw Thompson</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. S.

SEP 1 1957

RECEIVED

9417

Items 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

## CERTIFICATE OF DEATH

Reg. Dist. No.

10582

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Ironside - Md.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ironside</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>1</b>			
3. NAME OF DECEASED (Type or print) First <b>LEON</b> Middle <b>LORENZA</b> Last <b>ROSS</b>				4. DATE OF DEATH Month <b>9</b> - Day <b>30</b> Year <b>1957</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG. 15, 1917</b>	9. AGE (In years last birthday) <b>39</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Construction work</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>CHARLES HARRISON ROSS</b>				14. MOTHER'S MAIDEN NAME <b>KATE DENT</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>CHARLES HARRISON ROSS</b>				Address <b>Hilltop, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>INTRACRANIAL HEMORRHAGE</b>							<b>3 DAYS</b>
DUE TO <b>BASAL SKULL FRACTURE</b>							" "
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>AUTOMOBILE ACCIDENT</b>			
20c. TIME OF INJURY Month, Day, Year <b>9-27-57</b>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>HILLTOP MD</b>				20f. (City or town) <b>HILLTOP, MP.</b> (County) (State)			
21. I certify that I attended the deceased from <b>9-27</b> , 19 <b>57</b> , to <b>9-30</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>9-30-57</b> , 19 <b>57</b> , and that death occurred at <b>3:30 PM, EST</b> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <b>J. PARRAN JARBOE M.D.</b>				DATE SIGNED <b>10/1/57</b>			
PHYSICIAN'S NAME (Type) <b>J. PARRAN JARBOE M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>10-4-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Little Zion</b>		22d. LOCATION (City, town, or county) (State) <b>Hilltop, Charles, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Johnson and Jenkins</b>				24a. REC'D BY REGISTRAR <b>10/1/57</b>			
ADDRESS <b>4804 Georgia Ave. N.W.</b>				24b. REGISTRAR'S SIGNATURE <b>Mary Southland</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 3 1967

RECEIVED

9418

## CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waldorf</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Waldorf</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>IDA Florence Rowe</u>		4. DATE OF DEATH <u>SEPT 23</u> 19 <u>57</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 10 1891</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	
11. BIRTHPLACE (State or foreign country) <u>Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>CANADA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>C.A. Rowe</u>	
17. INFORMANT <u>Waldorf, MD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis, Spinal Cord</u> DUE TO (b) <u>Carcinoma, Primary, Pelvic</u> DUE TO (c) <u>19.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> 19 <u>40</u> to <u>Sept 23</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9-18</u> , 19 <u>57</u> , and that death occurred at <u>6:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George S. Weber, MD</u> M.D.		ADDRESS (Street, city or town, state) <u>Waldorf, MD</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>GEORGE S. WEBER, WILDFORD MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Sept 25 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Waldorf, MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home</u>		ADDRESS <u>Waldorf MD</u>	24b. REC'D BY REGISTRAR <u>9/30/57</u> DATE
		24c. REGISTRAR'S SIGNATURE <u>Julius T. Hasey</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 2 1911

RECEIVED  
OCT 2 1911



1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09423

## CERTIFICATE OF DEATH

9419

Reg. Dist. No. 100

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Charles</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>Charles</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN				TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Port Tobacco Md.</i>				STREET ADDRESS <i>Port Tobacco</i> (If rural give location)			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<i>Emattie D SIMPSON</i>				<i>SEPT. 10 19 57</i>			
<b>5. SEX</b>		<b>6. COLOR OR RACE</b>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>		<b>8. DATE OF BIRTH</b>	
<i>FEMALE</i>		<i>WHITE</i>				<i>Feb 7, 1882</i>	
						<i>75</i> yrs.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)	
<i>housewife</i>				<i>Port Tobacco Md</i>		<i>Md.</i>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<i>William H St Clair</i>				<i>Ann S Hancock</i>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
				<i>Emattie Simpson (husband)</i>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>4. IMMEDIATE CAUSE</b> (A)				<i>Myocardial Infarction</i>			
<b>ANTECEDENT CAUSE(S) DUE TO</b>				<i>Arteriosclerotic Heart Disease</i>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> (B)							
<b>DUE TO</b> (C)							
<b>11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
				<i>24 hours</i>			
<b>19a. DATE OF OPERATION</b>				<b>19b. MAJOR FINDINGS OF OPERATION</b>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <i>9 SEPT., 19 57</i>, to <i>10 SEPT., 19 57</i>, that I last saw the deceased alive on <i>9 SEPT., 19 57</i>, and that death occurred at <i>9:15 PM</i>, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>ADDRESS</b> (Street, city, town, state)		<b>DATE SIGNED</b>	
<i>Ernest B Settor</i>				<i>La Plata, Md.</i>		<i>12 SEPT, 1957</i>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<i>Burial</i>		<i>Sept 12, 1957</i>		<i>St Thomas</i>		<i>Chapel Point Md.</i>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<i>9/16/57</i>		<i>Julia H Pacey</i>		<i>Arthart Inc La Plata Md</i>			

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

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SEP 18 1957

BUREAU V. C.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9425

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0942400

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Physicians Mem. Hosp.</u>				d. STREET ADDRESS <u>Charlotte Hall</u>			
3. NAME OF DECEASED (Type or print) <u>WILLIAM FREDERICK SWANN</u> First Middle Last				4. DATE OF DEATH <u>SEPT. 28</u> Month Day Year			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 29, 1934</u>	9. AGE (In years last birthday) <u>23</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Charles Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel F. Swann Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Catherine I. Higgs</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-32-2452</u>		17. INFORMANT <u>Samuel F. Swann, Charlotte Hall, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage and Multiple Fractures</u> DUE TO <u>right forearm and right femur.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Auto accident.</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <u>Auto accident.</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u>1:40</u> a. m. <u>9-28</u> 19 <u>57</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>9/30/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Trinity Cem.</u>	
22d. LOCATION (City, town, or county) <u>Newport</u>				(State) <u>Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt &amp; Funeral Home</u>				ADDRESS <u>Weldorf, Md</u>		24a. REC'D BY REGISTRAR <u>10/1/57</u>	
24b. REGISTRAR'S SIGNATURE <u>John A. ...</u>							

MEDICAL CERTIFICATION

NOTARY PUBLIC

EXAMINER'S NAME (Type)

Vernon B. Dettor

VERNON B. DETTOR

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

SEPT. 28, 1957

TO THE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO THE FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

U.S. NAVY

1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09425

106

1. PLACE OF DEATH a. COUNTY <b>Charles</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Indian Head Md</b> c. LENGTH OF STAY IN 1b <b>3 1/2 Years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Indian Head Md</b> x d. STREET ADDRESS <b>Mattingly Ave.</b> / <b>Catholic Rectory</b> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Sweeney, John Thomas</b> (SWEENEY) First Middle Last				4. DATE OF DEATH <b>9-8-57</b> Month Day Year			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>W-US</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 30, 1910</b>	
9. AGE (In years last birthday) <b>47</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Priest.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Roman Cath.Ch.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md</b>	
12. CITIZEN OF WHAT COUNTRY? <b>US</b>							
13. FATHER'S NAME <b>Michael Sweeney</b>				14. MOTHER'S MAIDEN NAME <b>Anna Clinton</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Owen E. Sweeney-Balt., Md.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arterio Sclerosis</b> (c), stating the underlying cause last. <b>Indefinite</b> DUE TO						INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>James E. Andrews</b> EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>9-8-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/11/57</b>		22c. NAME OF CEMETERY <b>New Cathedral</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James T. Ryan, Inc.</b> ADDRESS <b>317 Pa. Ave., SE DC3</b>				24a. REC'D BY REGISTRAR <b>SEP 10 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Odey, Thayer</b>	

RECEIVED

SEP 10 1957

BUREAU V. B.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09426

Reg. Dist. No.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WHITE PLAINS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>White Plains</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>MILTON</b> Middle <b>W.</b> Last <b>SYDNOR</b>		4. DATE OF DEATH Month <b>September</b> Day <b>4</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 17, 1938</b>
9. AGE (In years last birthday) <b>19 yrs</b>		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b>	11. IF UNDER 24 HRS Hours <b>1</b> Min <b>1</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Store clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grocery</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington DC.</b>		12. CITIZEN OF WHAT COUNTRY? <b>US.</b>	
13. FATHER'S NAME <b>Samuel Sydnor</b>		14. MOTHER'S MAIDEN NAME <b>Leslie Montgomery</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>215 36 5633</b>	
17. INFORMANT <b>Samuel Sydnor</b>		Address <b>White Plains Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Rheumatic Pancarditis.</b> 401.3 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last, (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Paul F. Guerin</b>		DATE SIGNED <b>9/5/57</b>	
EXAMINER'S NAME (Type) <b>Paul F. Guerin, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Sept 3/1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Church &amp; God</b>	22d. LOCATION (City, town, or county) (State) <b>Shelton 217</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Samuel Sydnor</b>		24. REC'D BY REGISTRAR <b>SEP 10 1957</b>	

BUREAU V. S.

SEP 19 1967

RECEIVED

*[Handwritten signature]*



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9423

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 1 Film, 21 10-16-57 et

0942700  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles co</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE _____ b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Waldorf, Md.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>5012 5th St NW</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) -----		d. STREET ADDRESS <i>Wash D.C.</i>	
3. NAME OF DECEASED (Type or print) <i>DOUGLAS DURANT WILLIAMS, JR.</i>		4. DATE OF DEATH <i>SEPT. 28 1957</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2 FEB. 1931</i>
9. AGE (In years last birthday) <i>26</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Writer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Gen. Business</i>	
11. BIRTHPLACE (State or foreign country) <i>DW are streets D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Douglas D Williams</i>		14. MOTHER'S MAIDEN NAME <i>Louise Williams</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>249-44-4303</i>	
17. INFORMANT <i>Mrs D. Bayard Sinton</i>		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage and Multiple Skull Fractures</i> DUE TO <i>Cerebral Trauma - Auto Accident</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO _____ DUE TO _____		INTERVAL BETWEEN ONSET AND DEATH <i>0</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Auto accident</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>9-28 1957</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <i>Highway</i>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Vernon B. Dettor</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>VERNON B. DETTOR</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <i>28 SEPT. 1957</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Sept 28 1957</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Bagg Old Ward cemetery Washington D.C.</i>		22d. LOCATION (City, town, or county) _____ (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert M. Laplata mml</i>		24a. REC'D BY REGISTRAR DATE <i>10/1/57</i>	
		24b. REGISTRAR'S SIGNATURE <i>Julia H. Pacey</i>	

BUREAU V. S.

OCT 7

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No. 094280

9424

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>XO Faulkner</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Physicians Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>PERE</b> Middle <b>WILMER</b> Last <b>WILMER</b>				4. DATE OF DEATH Month <b>SEPT</b> Day <b>18</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 17, 1892</b>		9. AGE (In years last birthday) <b>65</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>US Govt.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Govt.</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>PERE WILMER</b>				14. MOTHER'S MAIDEN NAME <b>AMELIA MATTHEWS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT Address <b>MRS F. Hill Hamilton LA Plata, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory collapse.</b> <b>197X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Metastatic Carcinoma, generalized</b> DUE TO (c) <b>Prostatic Carcinoma</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b> <b>9 mo.</b> <b>1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Nov 1949</b> , 19___, to <b>Sept</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>18 Sept</b> , 19 <b>57</b> , and that death occurred at <b>3:05 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Arthur O Wooddy</b> M.D.				ADDRESS (Street, city or town, state) <b>La Plata, Md.</b> DATE SIGNED <b>18 Sept 57</b>			
PHYSICIAN'S NAME (Type) <b>ARTHUR O WOODDY</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>9-20-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>MT REST</b>		22d. LOCATION (City, town, or county) (State) <b>LA PLATA, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hunt Funeral Home</b>				ADDRESS <b>WALDORF, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>9/23/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Julia H. Pacey</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is mostly blank with some faint, illegible markings.

RECEIVED  
SEP 25 1957  
BUREAU V. R.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9425

CERTIFICATE OF DEATH

0942900  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hughesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>XO Hughesville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>C.</b> Last <b>Woodland</b>		4. DATE OF DEATH Month <b>Sept</b> Day <b>20</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 2, 1893</b>
9. AGE (In years last birthday) yrs. <b>64</b>		10. IF UNDER 1 YEAR: Months <b>64</b> Days <b>64</b> Hours <b>64</b> Min. <b>64</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>US.</b>		12. CITIZEN OF WHAT COUNTRY? <b>US.</b>	
13. FATHER'S NAME <b>Joseph Woodland</b>		14. MOTHER'S MAIDEN NAME <b>Anna ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>James E. Woodland</b>		Address <b>Hughesville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>430.1</b> DUE TO <b>recorded infection</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardio-vascular and renal disease</b> DUE TO <b>—</b> (c) <b>—</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 Day</b> <b>yes</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>—</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 15, 1957</b> to <b>Sept 1, 1957</b> , that I last saw the deceased alive on <b>Aug 15, 1957</b> , and that death occurred at <b>M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Richard H. Dobson</b> M.D. <b>B. H. Pusey</b>			
PHYSICIAN'S NAME (Type) <b>Richard H. Dobson</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9-23-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St Mary's Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Bryantown, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The Hunt Funeral Home</b>		ADDRESS <b>Waldorf, Md.</b>	
24a. REC'D BY REGISTRAR <b>9/23/57</b>		24b. REGISTRAR'S SIGNATURE <b>Julia H. Pusey</b>	

# CERTIFICATE OF DEATH

SEP 25 1957

BUREAU V. S.

RECEIVED